EC-2

Hawaii Employer-Union Health Benefits Trust Fund

ENROLLMENT FORM FOR RETIREES

Customer Service: Oahu – 586-7390 Toll Free: 1-800-295-0089

. Event:	
. Event Date:(MMIDD/YY)	
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		10111166: 1-000-233-0003											
See Instructions on reverse side BEFORE completing this form. Refer to your benefits guide or our website for plan													
3a. Employee's Last Name, First, M.I.							3b. Social Security Number (for new enrollees only) or EUTF ID Number:						
							4. If your spouse or Domestic Partner is a State or County						
changed):								Employee or Retiree, please provide their SSN or EUTF					
3d. City: 3e. State: 3f. Zip Code:							ID: If you are including your spouse or domestic partner in you						
								health benefits plans, please complete sections 5 - 9.					
3g. Marital Status: 3h. Gender: 3i. Birth Date:								3j. Home Phone 3k. Cell Phone Number					
☐ Married ☐ Single ☐ Male ☐ Female (MMIDD/YY) /							/	' Num	ber:				
5a.	5b.	6a Depe	ndents:			6b. Birth Dat	e	6c. SSNor	7.	8. Gend	der		
	Delete			M.I., Last Name (if different)			\	EUTF ID Number	Relationship	J. J			
						/ /	<u>'</u>	ID Number		□Male	Female		
						1 1				☐ Male	Female		
						1 1				☐ Male	Female		
9. Plan Selections, Changes or Cancellations - Make your selection by checking the box for the appropriate benefit													
plans below, Select Self, 2-Party, Family or Cancel/Waive coverage. Choose only one box in each plan section.													
	Section		Carrier Selection					Self	2-Party	Family	Waive/cancel		
			EUTF PPO Medical (HMA Network)										
Medical Plan (Only one selection allowed from this list)			EUTF PPO Medical (HMSA Network)										
			Kaiser Comprehensive HMO Medical and Drug)										
Prescription Drug													
			NMHC Prescription Drug										
with Kaiser HMO) Dental Plan			HDS Dental										
			VSP Vision										
			Standard Life Insurance										
10. If you or your dependent(s) are enrolled in a non-EUTF Medicare Part D drug plan, please read item 10 on the back of													
l l	•	, ,	`	,		non-EUTF Me		0 .					
11. Cartification (and instructions on the book of this form)													
11. Certification (see instructions on the back of this form)													
Retiree Signature:							Date:						
40.	IEDIA	ADE DAD	T D EN	DOLL MENT	01 1 0	274 00/4) 110		. 1: 1:		(11.	NA II		
12. MEDICARE PART B ENROLLMENT: Chapter 87A-23(4), HRS requires eligible beneficiaries to enroll in Medicare													
Part B as a condition of receiving contributions and participating in the EUTF benefit plans. If you or your dependent(s) recently enrolled in Medicare Part B, please submit a copy of the Medicare card and complete below:													
Name of enrollee: Medic					care	care Claim #:							
(iD number on the Medicare card)													

Please submit your signed and completed form via mail to: EUTF, P.O. Box 2121, Honolulu Hawaii 96805-2121 or you can fax it to 808-586-2161.



INSTRUCTIONS FOR COMPLETING EC-2 FORM

- A. Print or type clearly, if form is unreadable it may be sent back to you.
- B. Please submit form to the EUTF.
- C. This form is to be used effective January 1, 2009 or later.
- D. Sections:
 - 1. Event -Please describe the event. For example, Open Enrollment, Birth, Marriage, Divorce, Loss Coverage, Address Change, Marital Status Change, Death, Change in Student Status, Add Dependent, Cancel etc. If there are simultaneous events, please describe the most important event. For example, if the event is a Birth, enter Birth in the event section.
 - 2. Event Date Please enter the date the event took place.
 - 3. Enter Employee's information. For 3b, enter the EUTF ID #. If you are enrolling for the first time, you must enter your social security number.
 - 4. Enter EUTF ID # of Spouse or Domestic Partner if your spouse of Domestic Partner is a State or County Employee or Retiree. Be sure to complete sections 5 9, if you want to cover your spouse or domestic partner.
 - 5. Check "Add" box to add dependent, check "Delete" box to delete dependent
 - 6. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter the birth date and social security number. Otherwise, you may leave items 6b and 6c blank. If making changes to your dependent's data, enter the corrected item. If listing more than 3 dependents, write "Continued" on the last line of the Dependent section. Use a separate sheet of letter size paper to list additional dependent(s) information.
 - 7. Use the following codes for Relationship column:

SP = Spouse CH = Child DC = Disabled Child $^{1/2}$

DP = Domestic Partner
DPC = Domestic Partner Child

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For Relationship codes with $\sqrt[4]{}$ or $\sqrt[4]{}$, please see item #13 below for further instructions.

- 8. Gender circle either Male or Female.
- 9. Plan Selections. Only one plan from the Medical plans and the appropriate coverage for you may be selected. If you choose a medical plan, you now have the option to select or not to select NMHC if you also want prescription drug coverage. If you do not want any plan coverage, mark the "Cancel/Waive" box.
- 10. IMPORTANT: If you or your dependent(s) are Medicare eligible and are enrolled in a Non-EUTF Medicare Part D prescription drug plan, please provide the name(s) of those enrolled in the Non-EUTF plan. Please ensure that you carefully read the implications of being enrolled in a Non-EUTF Medicare Part D prescription drug plan. Additional information is included in your 2009 Retiree Open Enrollment Guide. You can obtain detailed information regarding Medicare Part D at the Medicare website, www.medicare.gov.
- 11. Certification: Signature of Employee certifies that the information provided in this application is true and complete. Employee agrees to abide by the terms and conditions of the benefit plans selected. Employee affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student. Please enter date of Employee's signature.
- 12. IMPORTANT NOTICE: When you or your spouse become eligible for Medicare, you or your spouse must enroll in Medicare Part B and forward a proof of enrollment to the EUTF. Failure to comply may result in loss of all health benefits coverage. If you or your dependents have recently enrolled with Medicare Part B, please complete this section and submit the form and a copy of your Medicare card or the letter notifying you of your enrollment in Medicare Part B to the EUTF.
- 13. If you are adding a disabled child, domestic partner and child or an adopted child, please contact the EUTF at 808-586-7390 or toll free, 1-800-295-0089 or go to our website at www.eutf.hawaii.gov for more information.